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Fetal, Infant and Child Death in Montana

Summary of 2003-2004 Mortality Reviews

December 2006

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Fetal, Infant and Child Death in Montana

A summary of mortality reviews conducted in 2003 and 2004

Montana Fetal, Infant, and Child Mortality Review Mission

To identify, address and potentially decrease the numbers of preventable fetal, infant and child deaths in the state of Montana.

December 2006



This report is dedicated to the memory of the Montana children who died in 2003 and 2004.

The DPHHS Family and Community Health Bureau would like to thank the following people for their work and professional guidance on this report.

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With special acknowledgement and gratitude to Wilda McGraw, R.N., who coordinated the FICMR project for the state of Montana until her retirement in 2006.

Introduction

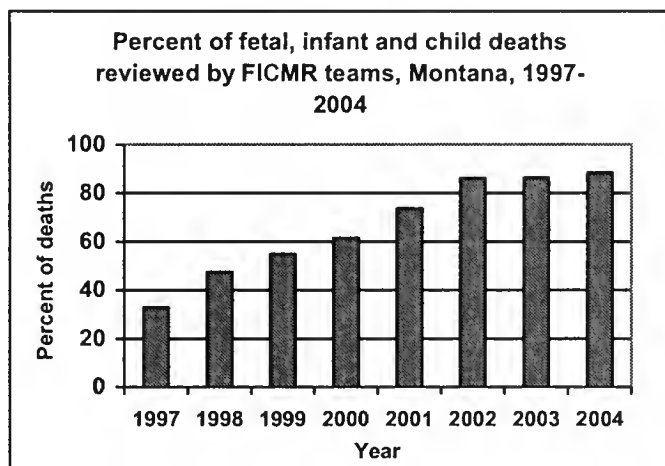
Every child's death is a tragedy. While we cannot undo the circumstances surrounding the deaths, we can learn from them and act to prevent similar deaths in the future.

The Montana Fetal, Infant and Child Mortality Review (FICMR) Program was established by the Montana legislature in 1997. In 2003-2004, 53 of Montana's 56 counties and all seven Indian Reservations participated in FICMR reviews through 30 local FICMR teams. FICMR teams include coroners, law enforcement officials, physicians, public health nurses, social workers, mental health professionals, school officials, tribal representatives, and county attorneys. The teams meet as needed to confidentially review records and information pertaining to each death.

The intent of the FICMR program is to perform comprehensive case reviews on child and infant deaths and stillborn fetuses in Montana to develop a greater understanding of the causes of death and identify strategies for preventing deaths. In cases where there is enough information to do so, the teams determine whether a death was preventable. Understanding the circumstances around a death may help a community to understand the risk factors affecting the health and well-being of their youth. Review results can lead to state, local and national policies and actions to prevent deaths in the future.

FICMR reports are produced biennially and include data for a two-year period. The reports include information from two sources: death records from the Montana Office of Vital Statistics, and the results of all FICMR reviews completed by Montana FICMR teams. The death record database includes all deaths reported in Montana for the years of interest, as well as most of the deaths of Montana residents who die out

of state during the same time period. The death records and FICMR review records are matched to provide more complete information on Montana deaths. Death record information is used during the FICMR reviews, except in the few cases when it is unavailable at the time of the review.



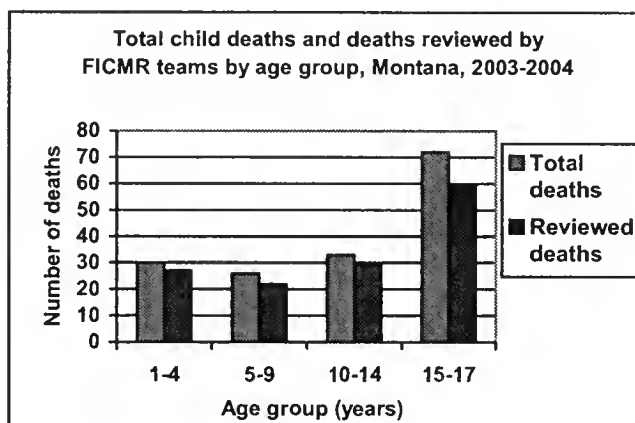
In 2003-2004, 394 fetal, infant and child deaths were recorded in Montana or to Montana residents. Three hundred and forty of those deaths (86%) were

reviewed by FICMR teams. An additional four deaths were reviewed, but were not linked to a death record. Twenty of the 394 deaths and ten of the 344 reviews were infants and children who died in Montana, but were not Montana residents.

Forty-three Montana counties had at least one reported fetal, infant or child deaths in 2003-2004. Thirteen counties had no fetal, infant or child deaths.

The following definitions are used in determining how a death is classified as fetal, infant or child:

- Fetal death: a stillborn delivery with weight at least 350 grams, or, if the weight is unknown, a stillborn fetus that has reached 20 weeks gestation.
- Infant death: a live-born baby whose death occurred at less than one year of age
- Child death: a child whose death occurred at one year of age up through their 17th year.



Among the 2003-2004 deaths that were reviewed, 90 were fetal, 115 were infant, and 139 were child deaths.

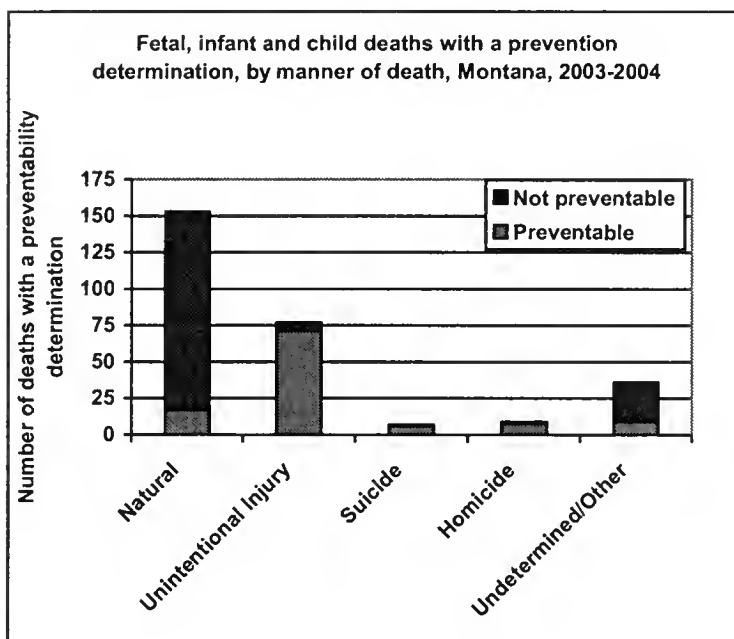
Preventability

During the FICMR reviews, the multi-disciplinary teams assess whether there is enough information on the death to determine whether it was preventable. A child's death is considered to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death.

In 2003-2004, 282 (83%) of the 344 deaths reviewed received a preventability determination. Seventy-four percent of the deaths with a prevention determination were child deaths, 19% were infant deaths and 7% were fetal deaths. 111 deaths (39% of those reviewed for preventability) were judged to be preventable and 171 were considered not preventable.

The preventability of a death is strongly related to the cause of death, and the cause of death is associated with the age of the decedent. Fetal and infant deaths are more likely to be attributed to natural causes (deaths not due to external causes), and the majority of natural cause deaths are determined to be

not preventable. Child deaths are more likely to be due to accident or violence, which are causes of death more likely to be determined preventable.



In Montana in 2003-2004, the largest numbers of deaths were natural deaths among infants and accidental deaths among children. Twelve of the 80 infant natural deaths (15%) with a preventability determination were identified as definitely preventable. Eight of these twelve deaths were SIDS, and all eight had at least one identified risk factor (see Appendix F for a list of SIDS risk factors). Over 90% (65 of 70) of the accidental deaths of

children were identified as definitely preventable, and 14 of the 16 intentional (homicide or suicide) child deaths were preventable.

Preventability by Age Group and Manner of Death						
<i>Manner</i>	Child deaths		Infant deaths		Fetal deaths	
	<i>Definitely preventable</i>	<i>Not at all preventable</i>	<i>Definitely preventable</i>	<i>Not at all preventable</i>	<i>Definitely preventable</i>	<i>Not at all preventable</i>
Natural	2	31	12	68	3	37
Unintentional Injury	65	5	4		2	1
Suicide	6	1				
Homicide	8	1				
Undetermined	1		5	1	1	1
NA (Fetal)					2	25
Total	82	38	21	69	8	64

Child abuse and neglect

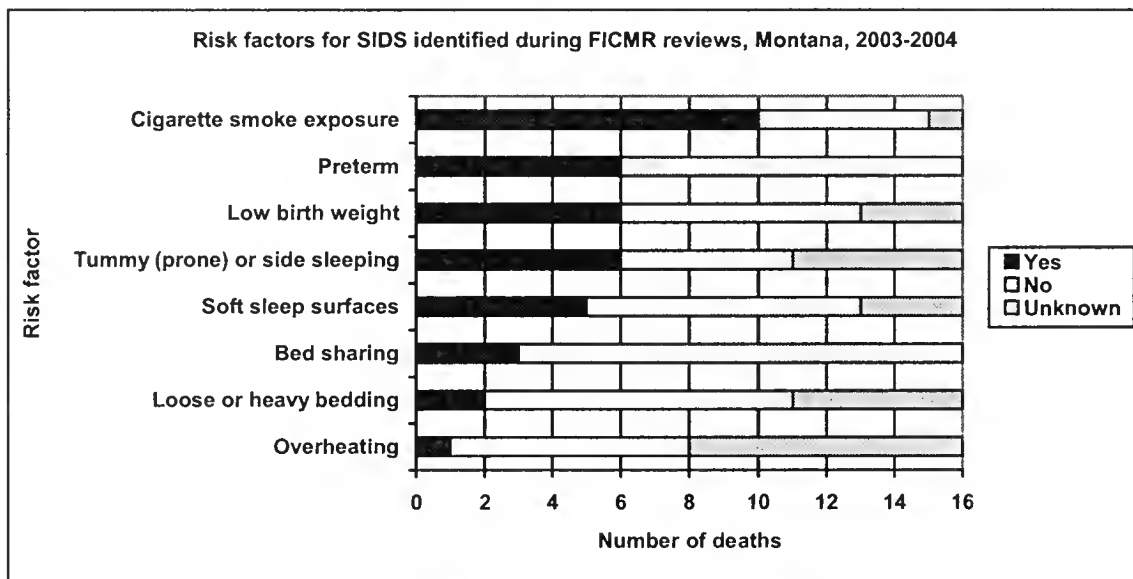
Fifteen of the 2003-2004 FICMR reviews identified child abuse and/or neglect as the cause of death. Seven of these abuse-related deaths were children less than five years of age. Five of the deaths were children ages 10 or 11, and the remaining three were teens 14 to 16 years of age. Eight of the 15 cases had inadequate supervision at the time of death and two cases were from alcohol poisoning. Two other deaths cited "drinking" as the activity at the time of death.

Eleven of the deaths due to maltreatment were among male infants and children. Five of the 15 cases had a prior history of maltreatment.

Sudden Infant Death Syndrome (SIDS)

In 2003-2004, SIDS was the second leading cause of death among infants in Montana. Vital statistics data identified 17 SIDS deaths in 2003-2004. Fourteen of these SIDS cases were reviewed by FICMR teams, and teams reviewed an additional two SIDS deaths that were not linked with a death certificate. The discussion of reviewed SIDS deaths includes sixteen deaths.

Eleven of the reviewed SIDS cases had enough information to determine whether they were preventable. Eight of the 11 were determined to be preventable and three were judged not preventable. Twelve of the SIDS deaths occurred in the infant's home, three occurred in "other home", and one in a licensed day care setting. Two reviews identified no known risk factors for SIDS in the circumstances surrounding the infant's death, four identified one known risk factor for SIDS, two identified two risk factors, five identified three risk factors, and three identified four or more risk factors for SIDS during the review of the infant's death. Exposure to cigarette smoke, whether via the mother's use of tobacco during pregnancy, second-hand smoke in the home, or both, was the most frequently cited risk factor.

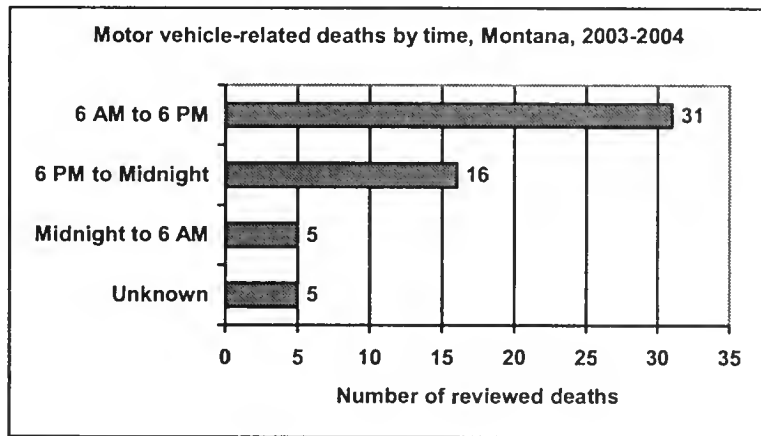


Motor vehicle-related incidents

Motor vehicle-related fatalities account for the largest portion of unintentional injury deaths among infants and children in Montana. Of the 92 infant and child

deaths due to unintentional injuries in 2003-2004, Montana death records indicate that 65 (71%) were motor vehicle-related (including boats, bicycle, airplane and pedestrian deaths). One fetal death occurred secondary to a motor vehicle crash.

Fifty-seven of the 65 motor vehicle-related deaths were reviewed by FICMR teams. Twenty four of these deaths occurred among girls and 33 among boys. Nine of the 24 girls who died were drivers, while 11 of the 33 boys were drivers. Thirty-two of the children who died in motor vehicle-related



incidents were 15-17 years of age, 15 were 10-14 years, 4 were 5-9 years and 3 were 1-4 years. Two infant deaths and one fetal death were also attributed to motor vehicles. Most of the motor vehicle fatalities occurred between 6 am and 6 pm.

In nineteen cases the drivers involved were less than 16 years of age, of these, four were less than 15 years of age. Driver error was cited as a contributing factor in 31 of the motor vehicle-related fatalities. Eleven of these 31 cases also included speeding as a contributing reason. Six of these 11 also cited alcohol/drugs as a contributing factor to the motor vehicle related fatality.

Fifty-three of the 57 motor vehicle-related deaths reviewed by FICMR teams received a preventability determination. Forty-nine of the cases were determined to be preventable and five cases were judged not preventable.

Contributing factors to motor vehicle-related fatalities in fetal, infant and child deaths, in Montana, 2003 - 2004		
Contributing factor	Mentioned alone	Mentioned with another contributing factor
Speeding	0	18
Recklessness	2	7
Mechanical Failure	0	0
Poor Weather	2	5
Driver Error	14	17
Alcohol/Drugs	2	10
Other	6	9

Factors in the preventable deaths included the failure to use seatbelts and child seats. Five infants and children under the age of seven were killed in motor vehicle crashes. Only two of these individuals were in infant seats and properly restrained; two others were improperly restrained and one was not restrained. Among older children, a seatbelt

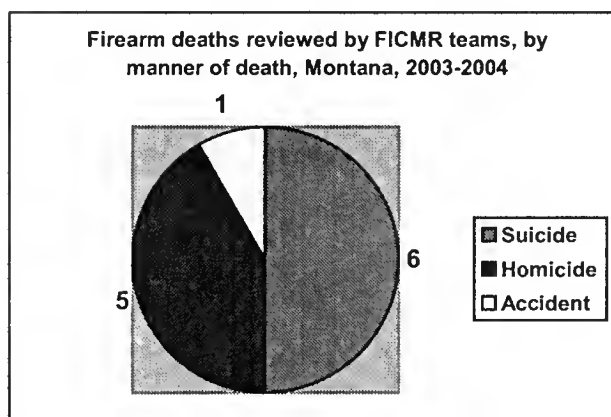
was present but was not used by 18 (75%) of the 24 individuals who died in a motor vehicle crash. In only three cases was the seatbelt present and used correctly.

Twelve of the motor vehicle-related fatalities of infants and children in Montana were alcohol-related.

Twenty-four of the motor vehicle-related fatalities in Montana in 2003-2004 were teens 15 to 17 years old in cars or pick-up trucks. Eleven were drivers, 11 were passengers and the position in the vehicle for the remaining two was reported as "unknown" or "other."

Firearms

In Montana during 2003-2004, 12 fetal, infant and child deaths reviewed by FICMR teams were attributed to a firearm injury. Six of these cases were suicides, five were homicides and one was an accidental discharge of a firearm. Ten of the firearm-related deaths had preventability determinations; eight were determined to be preventable and two were determined not to be preventable.



Suicide

Eleven youth suicides occurred during 2003-2004 in Montana. Seven boys and four girls completed suicide; nine of the decedents were white, one Native American and one of unspecified race. Ten of the eleven decedents fell into the 15 to 17 years age group and one victim was 14 years old. Firearms were used in six of the suicides and hanging was the method of death in the other five cases.

Ten of the eleven suicide cases were reviewed by FICMR teams. One of the reviews reported a history of child maltreatment and five indicated a history of mental health problems. Seven of the suicide cases occurred in the decedent's home. Seven of the cases had toxicology screens, and none of those tested were positive for alcohol or illicit drugs. A preventability determination was made for seven of the suicide cases; six of the suicides were determined to be preventable and one case was not.

Homicide

Eleven children died by homicide in Montana in 2003-2004. Five of the homicides were perpetrated with a firearm, two with a knife and two with "other means." One homicide was due to poisoning and one to maltreatment. Five of the homicide victims were aged 1 to 4 years, four aged 15 to 17 years, and the other two victims were six and ten years old.

Ten of the homicides were reviewed by FICMR teams, and nine received a preventability determination. Eight cases of those were considered preventable and one was judged not preventable. Three of the homicide victims had a history of child abuse or neglect. A toxicology screen was reported for four victims, two tested positive for alcohol and one for tetrahydrocannabinol (THC).

Drowning

In 2003-2004, ten drowning fatalities occurred in Montana. Four cases occurred among children aged 1 to 4 years, two to children 5 to 9 years and four to children aged 15 to 17 years. All ten of the drowning deaths were reviewed by FICMR teams and eight of them received preventability determinations. Seven of the deaths were judged preventable and one case was considered not preventable. Seven drowning deaths occurred in lakes, ponds, or rivers, two occurred in drainage/irrigation ditches, and one in an above-ground pool. Four toxicology screens were reported, and one teenager tested positive for alcohol. One caregiver associated with a death also tested positive for alcohol.

FICMR Summary

- Eighty-two (68%) of the 120 child deaths with a preventability determination were preventable.
- Twenty-one (23%) of the 90 infant deaths with a preventability determination were preventable.
- Eight (11%) of the 72 fetal deaths with a preventability determination were preventable.
- The majority of infant deaths occurred in the first 6 days of life (60 cases) or in the post-neonatal period (days 28 to 364) (59 cases).
- The leading cause of deaths for infants 28 to 364 days of age in 2003-2004 was SIDS (16 cases).
- Eight of the eleven SIDS cases reviewed for preventability were determined to be preventable. All eight had at least one identifiable risk factor.
- Tobacco use during pregnancy was reported in 44% of the infant deaths and 26% of the fetal deaths.
- Motor vehicle-related incidents were the leading cause of death in 2003-2004 for children ages 10-14 and 15-17 years.
- Forty-nine (86%) of the 57 motor vehicle-related deaths reviewed for preventability were determined to be preventable.
- Among children older than seven, a seatbelt was present and not used by 18 (75%) of the 24 individuals who died in a motor vehicle crash.
- Only 2 of the 5 infants and children under seven years of age killed in motor vehicle crashes were in child seats and properly restrained.
- Suicide was the second leading cause of death for children 15 to 17 years of age. Firearms and hanging were the most common methods.
- Eight of the ten firearm deaths reviewed were determined to be preventable.

Appendices:

Appendix A: Montana Resident Fetal, Infant and Child Deaths by County and Region, 2003-2004

Appendix B: Montana State FICMR Team

Appendix C: Local FICMR Team Coordinators

Appendix D: Intervention Activities Identified by Montana Communities

Appendix E: SIDS Risk Factors

Appendix F: Montana Code Annotated

Appendices

Appendix A: Montana Resident Fetal, Infant and Child Deaths by County and Region, 2003-2004

Total resident fetal, infant and child deaths, by county of residence, Montana 2003-2004

County	Resident FIC deaths	Reviewed resident FIC deaths
Beaverhead	2	2
Big Horn	4	4
Blaine	1	1
Broadwater	1	1
Carbon	2	2
Carter	2	
Cascade	41	41
Chouteau	1	1
Custer	4	3
Daniels		
Dawson	4	4
Deer Lodge	6	5
Fallon	1	1
Fergus	3	2
Flathead	37	35
Gallatin	29	25
Garfield		
Glacier	15	5
Golden Valley	2	1
Granite	2	2
Hill	11	10
Jefferson	2	2
Judith Basin		
Lake	21	21
Lewis & Clark	17	16
Liberty		
Lincoln	6	5
Madison		
McCone		
Meagher		
Mineral	3	2
Missoula	32	25
Musselshell	2	1
Park	6	5
Petroleum		
Phillips	2	2
Pondera	2	1
Powder River		
Powell	3	2
Prairie	1	1
Ravalli	16	15
Richland	2	2
Roosevelt	12	12

Rosebud	10	9
Sanders	8	8
Sheridan		
Silver Bow	17	15
Stillwater	3	3
Sweetgrass	1	1
Teton	2	1
Toole		
Treasure		
Valley	1	1
Wheatland	1	
Wibaux		
Yellowstone	36	35

TOTAL 374 330

Proportion of MT

Resident Deaths 88.2

Reviewed

* Please note that these numbers do not include the 4 reviews that were not linked to a death record.

Total resident fetal, infant and child deaths, by region, Montana 2003-2004

Region	Resident FIC deaths	Reviewed resident FIC deaths
1 (Eastern)	39	35
2 (North Central)	73	60
3 (South Central)	54	49
4 (South Western)	85	75
5 (North Western)	123	111
TOTAL	374	330

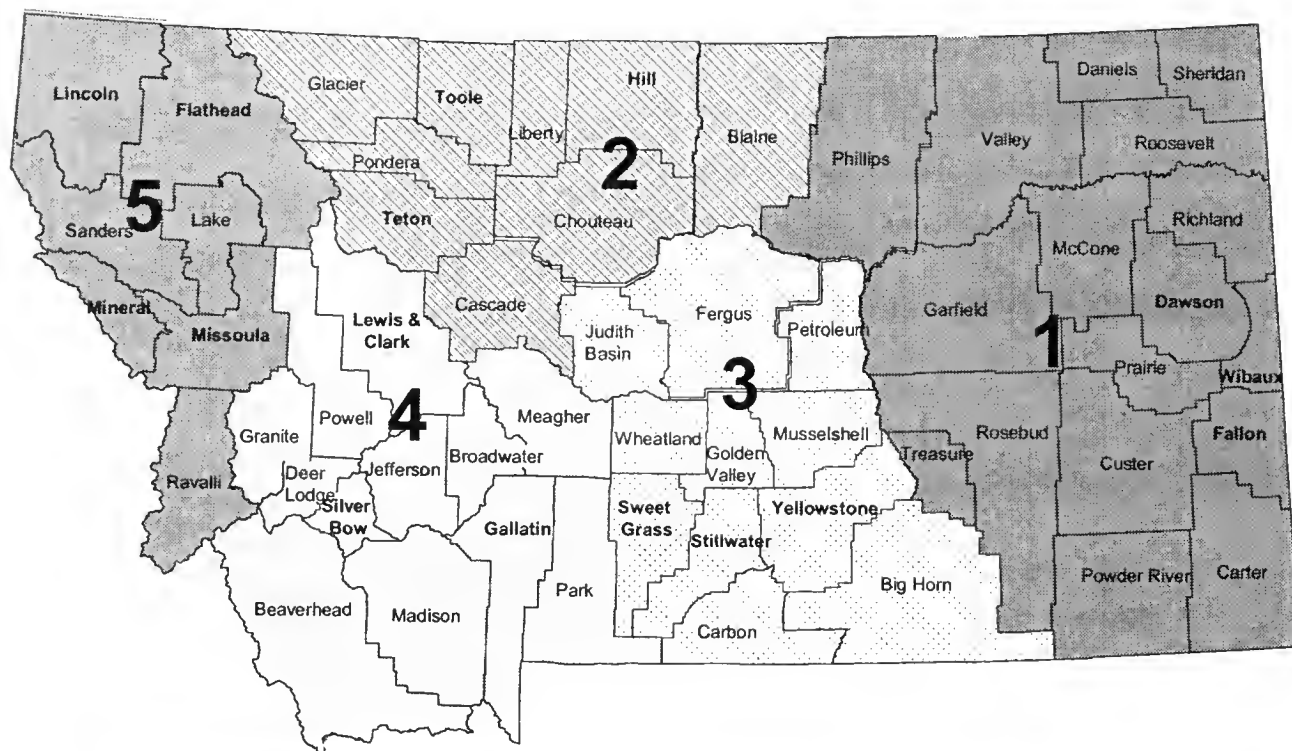
* Please note that these numbers do not include the 4 reviews that were not linked to a death record.

Proportion of resident fetal, infant and child deaths reviewed, by region, Montana 2003-2004

Region	Fetal deaths	Infant deaths	Child deaths
1 (Eastern)	88.9	100.0	81.3
2 (North Central)	92.9	79.3	80.0
3 (South Central)	93.8	93.8	86.4
4 (South Western)	89.3	86.7	88.9
5 (North Western)	92.9	85.4	92.6

* Please note that these calculations do not include the 4 reviews that were not linked to a death record.

Montana Health Planning Regions



Region I Eastern	Region II North Central	Region III South Central	Region IV South Western	Region V North Western
Carter Custer Daniels Dawson Fallon Garfield McCone Phillips Powder River Prairie Richland Roosevelt Rosebud Sheridan Treasure Valley Wibaux <i>(Ft Peck Reservation)</i>	Blaine Cascade Choteau Glacier Hill Liberty Pondera Teton Toole <i>(Blackfeet, Rocky Boys & Ft Belknap Reservations)</i>	Big Horn Carbon Fergus Golden Valley Judith Basin Musselshell Petroleum Stillwater Sweet Grass Wheatland Yellowstone <i>(Crow & Northern Cheyenne Reservation)</i>	Beaverhead Broadwater Deer Lodge Gallatin Granite Jefferson Lewis & Clark Madison Meagher Park Powell Silver Bow	Flathead Lake Lincoln Mineral Missoula Ravalli Sanders <i>(Flathead Reservation)</i>

Appendix B: Montana State FICMR Team

The Department of Public Health and Human Services gratefully acknowledges the State FICMR team members for their commitment to make Montana a safer place for children to live.

Linda Best, RN, Deer Lodge County
Rural County Representative

JoAnn Birdshead, Social Services
Bureau of Indian Affairs

Susan Court, Health Education Specialist
Office of Public Instruction

Gary Dale, MD
Medical Examiner

Matt Dale, Director
Office of Consumer Protection & Victim
Services
Department of Justice

Jim Edgar, MCH, State Registrar/Supervisor
Office of Vital Statistics
Department of Public Health and Human
Services

Dianna Frick, MCH Epidemiologist
Family and Community Health Bureau
Department of Public Health and Human
Services

Judy Griffin, RN, Ravalli County
Urban County Alternate

Steve Helgersen, MD, Medical Director
Department of Public Health and Human
Services

Betty Hidalgo, Chairman
Children's Trust Fund

Diane Jeanotte, RN
Maternal Child Health Coordinator
Indian Health Service

Bill Jones, Yellowstone County Coroner and
Mt Sheriff's and Peace Officers Association

John Johnson, MD, Geneticist
Shodair Children's Hospital

Willy Kemp, MD
Deputy Medical Examiner

Sam Kinser, Chaplin
Yellowstone County Sheriff's Office

Jeni Leary, Child Protective Services
Department of Public Health and Human
Services

Gary James Melbourne
Fort Peck Tribal Health Director

Cindy Morgan, RN, Sanders County
Rural County Alternate

Mary Nyhus, RN, Roosevelt County
Frontier County Alternate

Bobbi Perkins, EMS
Department of Public Health and Human
Services

Molly Peterson, RN, Madison County Public
Health
Frontier County Representative

Jim Reynolds MD, Geneticist
Shodair Children's Hospital

Karl Rosston, Social Services Director
Shodair Children's Hospital

Janet Runnion, RN, Rocky Boy
Reservation Representative

Nels Sanddal, President and CEO
Critical Illness and Trauma Foundation

Pat Sauer, MD, Pediatrician
Billings Deaconess Hospital

Mike Swingley, Trooper
MT Highway Patrol

Tamalee Taylor, RN, Yellowstone County
Urban County Representative

Steve Yeakel
Executive Director
Montana Council for Maternal & Child Health

Appendix C: Local FICMR Team Coordinators

The Department of Public Health and Human Services gratefully acknowledges the local FICMR team coordinators and members for their commitment to make Montana a safer place for children to live.

Beaverhead County

Sue Hansen, RN

Blackfeet

Terri Hensley, MD

Blaine County

Frances Hodgson, RN

**Partners with Hill County*

Broadwater County

Tish Fortier, RN

**Partners with Lewis and Clark County*

Big Horn County

Bill Hodges, Esther Wynne, RN,

Lori Byron, MD

**Partners with Crow Agency, Northern Cheyenne, Rosebud County, Treasure County*

Carbon County

Sharyl McDowell, RN

Cascade County

Carol Keaster, RN

**Partners with Choteau County, Liberty County, Meagher County, Pondera County, Teton County, Toole County*

Choteau

Angel Johnson, RN, APRN

**Partners with Cascade County*

Crow Agency

Bill Hodges, Esther Wynne, RN, Lori Byron, MD

**Partners with Big Horn County, Northern Cheyenne, Rosebud County, Treasure County*

Custer County

Terri Mayberry, RN, Alice K. Schweigert, RN

**Partners with Fallon County, Powder River County and Prairie County*

Daniels County

**Partners with Sheridan County*

Dawson County

Jeanne Seifert, RN

**Partners with Wibaux County*

Deer Lodge County

Linda Best, RN

**Partners with Powell County*

Fallon County

**Partners with Custer County*

Fergus County

Laurie Jergesen, RN

**Partners with Judith Basin County, Petroleum County and Wheatland County*

Flathead County

Boni Stout, RN

**Partners with Lincoln County*

Fort Belknap

Cindy LaMere, RN

**Partners with Hill County*

Fort Peck

Sue Snitker, RN

**Partners with Roosevelt County*

Gallatin County

Rebecca Spear, RN

Glacier County

Carol McDivitt, RN

Golden Valley County

**Partners with Yellowstone County*

Granite County

Barbara Tymofichuk, RN

Hill County

Danielle Golie, RN

**Partners with Blaine County, Fort Belknap, Phillips County, Rocky Boy*

Jefferson County

Tish Fortier, RN

**Partners with Lewis and Clark County*

Judith Basin County

**Partners with Fergus County*

Lake County

Linda Davis, RN, Barbara Plouffe, RN

Lewis and Clark County

Deb Kirley, RN

**Partners with Broadwater County and Jefferson County*

Liberty County

Karla Kulpas, RN

**Partners with Cascade County*

Lincoln County

Karol Spas-Otte, RN

**Partners with Flathead County*

Madison County

Molly Peterson, RN

Meagher County

Debi Downing, RN

**Partners with Cascade County*

Mineral County

Peggy Stevens, RN

Missoula County

Laura Scott, RN (through Oct. 2006),
Trudy Mizner, RN (as of Nov.2006)

Musselshell County

**Partners with Yellowstone County*

Northern Cheyenne

Janet Wolfname, RN

**Partners with Big Horn County and Crow Agency*

Park County

Mary Eisvang, RN

Petroleum County

**Partners with Fergus County*

Phillips County

Mary Lou Broadbrooks, RN

**Partners with Hill County*

Pondera County

Cynthia Grubb, RN

**Partners with Cascade County*

Powder River County

**Partners with Custer County*

Powell County

Nancy Nelson, RN

**Partners with Deer Lodge County*

Prairie County

**Partners with Custer County*

Ravalli County

Judy Griffin, RN

Richland County

Kathy Helmuth, RN

Rocky Boy

Janet Runnion, RN

**Partners with Hill County*

Roosevelt County

Mary Nyhus, RN

**Partners with Fort Peck*

Rosebud County

Ginger Roll, RN

**Partners with Big Horn County and Crow Agency*

Salish Koontenai Tribal Health

Linda Davis, RN, Barbara Plouffe, RN

Sanders County

Cindy Morgan, RN

Sheridan County

Kathy Jensen, RN

**Partners with Daniels County*

Silver Bow County

Marcia Murja, RN

Stillwater County

Bonnie Chepulis, RN, Kelly Shumway, RN

Sweet Grass County

Jeanne Conner, RN, Barb Beaver, RN

Teton County

Lora Wier, RN

**Partners with Cascade County*

Toole County

Karen Dobson, RN

**Partners with Cascade County*

Treasure County

Deb French, RN

**Partners with Big Horn County and Crow Agency*

Valley County

Vickie Bell, RN

Wheatland County

**Partners with Fergus County*

Wibaux County

Barb Maus, RN

**Partners with Dawson County*

Yellowstone County

Tamalee Taylor, RN

**Partners with Musselshell County and Golden Valley County*

Appendix D: Intervention Activities Identified by Montana Communities

Community activities identified by the local and state FICMR teams during 2003 and 2004 are as follows:

- Car Seat checkups and information with Safe Kids Safe Communities
- Seat belt checkup and education in high school parking lots
- Community Forums, providing education on prevention of teen alcohol use and driving.
- Communication with Montana DOT about concerns, safety issues relating to certain highway sections and intersections.
- Educational Materials to primary care clinics, hospitals, and daycares for Safe Sleeping, Back to Sleep, and Crib Safety
- Offered Video about “Period of Purple Crying” to hospitals for new parents to view to help prevent shaken baby syndrome.
- Promotion of gun safety with information about locking guns in a safe and storing ammunition in a different place.
- Promotion of gun safety education for all 12 year olds.
- Promotion of community service for free gun locks for every gun sold.
- Encourage schools and communities to learn about suicide prevention through the QPR (Question, Persuade and Refer) program
- Encourage a psychological autopsy as part of the death investigation of suicides.
- Suicide prevention and awareness activities with schools and parents.
- Life Jacket program (proper use) education by Safe Kids Safe Communities
- Public Service Announcement on correct use of propane heaters.
- Farm Safety education
- Promote use of helmets through free helmet program for skate boarding, skiing, biking, horseback riding and sledding.
- Education of pregnant women about fetal movements through the March of Dimes Kicks Count and motion matters programs
- Helping pregnant and new mothers get to Medical care appointments
- Smoking Cessation education
- Education about detection of methamphetamine use.

This list shows intervention activities reported by communities with FICMR activities. Please note that not all of these strategies have been evaluated.

Appendix E: Montana Code Annotated

Risk Factors for SIDS¹	
<i>The cause of SIDS is currently unknown. Several factors have been identified that increase an infant's risk for SIDS.</i>	
Tummy (prone) or side sleeping	Infants who are put to sleep on their tummy or side are more likely to die from SIDS than infants who sleep on their backs.
Soft sleep surfaces	Sleeping on a waterbed, couch, sofa, or pillows, or sleeping with stuffed toys has been associated with an increased risk for SIDS.
Loose bedding	Sleeping with pillows or loose bedding such as comforters, quilts, and blankets increases an infants risk for SIDS.
Overheating	Infants who overheat because they are overdressed, have too many blankets on, or are in a room that is too hot are at a higher risk of SIDS.
Smoking	Infants born to mothers who smoke during pregnancy are at increased of SIDS. Also, infants exposed to smoke at home or at daycare are more likely to die from SIDS.
Bed sharing	Sharing a bed with anyone other than the parents or caregivers and with people who smoke or are under the influence of alcohol or drugs, increases an infant's risk for SIDS. The safest place for an infant to sleep is in their own crib or other separate safe sleep surface next to the parent or caregiver's bed.
Preterm and low birth weight infants	Infants born premature or low birth weight are more likely to die from SIDS.

¹ <http://www.cdc.gov/SIDS/riskfactors.htm>. Last accessed December 11, 2006.

Appendix F: SIDS Risk Factors

Montana Code Annotated 2005

TITLE 50. HEALTH AND SAFETY CHAPTER 19. PREGNANT WOMEN AND NEWBORN INFANTS

Part 4. Fetal, Infant and Child Mortality Act

50-19-401. Short title. This part may be cited as the "Fetal, Infant, and Child Mortality Prevention Act".

History: En. Sec. 1, Ch. 519, L. 1997.

50-19-402. Statement of policy -- access to information. (1) The prevention of fetal, infant, and child deaths is both the policy of the state of Montana and a community responsibility. Many community professionals have expertise that can be used to promote the health, safety, and welfare of fetuses, infants, and children. The use of these professionals in reviewing fetal, infant, and child deaths can lead to a greater understanding of the causes of death and the methods of preventing deaths. It is the intent of the legislature to encourage local communities to establish voluntary multidisciplinary fetal, infant, and child mortality review teams to study the incidence and causes of fetal, infant, and child deaths and make recommendations for community or statewide change, if appropriate, that may help prevent future deaths.

(2) A health care provider may disclose information about a patient without the patient's authorization or without the authorization of the representative of a patient who is deceased upon request of a local fetal, infant, and child mortality review team. The review team may request and may receive information from a county attorney as provided in 44-5-303(4), from a tribal attorney, and from a health care provider as permitted in Title 50, chapter 16, part 5, or applicable federal law. The review team shall maintain the confidentiality of the information received.

(3) The local fetal, infant, and child mortality review team may:

- (a) perform an indepth analysis of fetal, infant, and child deaths, including a review of records available by law;
- (b) compile statistics of fetal, infant, and child mortality and communicate the statistics to the department of public health and human services for inclusion in statistical reports;
- (c) analyze the preventable causes of fetal, infant, and child deaths, including child abuse and neglect; and
- (d) recommend measures to prevent future fetal, infant, and child deaths.

(4) A local fetal, infant, and child mortality review team may not review deaths of fetuses, infants, or children who are Indians and which deaths occur within the boundaries of an Indian reservation with a tribal government that opposes the review.

History: En. Sec. 2, Ch. 519, L. 1997; amd. Sec. 11, Ch. 396, L. 2003; amd. Sec. 1, Ch. 413, L. 2003.

50-19-403. Local fetal, infant, and child mortality review team. (1) A local fetal, infant, and child mortality review team must be approved by the department of public health and human services. Approval may be given if:

- (a) the county health department, a tribal health department, if the tribal government agrees, or both are represented on the team and the plan provided for in subsection (1)(d) includes the roles of the county health department, tribal health department, or both;
- (b) a lead person has been designated for the purposes of management of the review team;
- (c) at least five of the individuals listed in subsection (2) have agreed to serve on the review team; and

(d) a plan has been developed by the team that includes, at a minimum, operating policies of the review team covering collection and destruction of information obtained pursuant to 44-5-303(4) or 50-19-402(2).

- (2) If a local fetal, infant, and child mortality review team is established, the team must be multidisciplinary and may include only:
- (a) the county attorney or a designee;
 - (b) a law enforcement officer;
 - (c) the medical examiner or coroner for the jurisdiction;
 - (d) a physician;
 - (e) a school district representative;
 - (f) a representative of the local health department;
 - (g) a representative from a tribal health department, appointed by the tribal government;
 - (h) a representative from a neighboring county or tribal government if there is an agreement to review deaths for that county or tribe;
 - (i) a representative of the department of public health and human services;
 - (j) a forensic pathologist;
 - (k) a pediatrician;
 - (l) a family practice physician;
 - (m) an obstetrician;
 - (n) a nurse practitioner;
 - (o) a public health nurse;
 - (p) a mental health professional;
 - (q) a local trauma coordinator;
 - (r) a representative of the bureau of Indian affairs or the Indian health service, or both, who is located within the county; and
 - (s) representatives of the following:
 - (i) local emergency medical services;
 - (ii) a local hospital;
 - (iii) a local hospital medical records department;
 - (iv) a local fire department; and
 - (v) the local registrar.
- (3) The designated lead person for the team shall submit membership lists to the department of public health and human services annually.

History: En. Sec. 3, Ch. 519, L. 1997; amd. Sec. 2, Ch. 413, L. 2003.

50-19-404. Records -- confidentiality. Material and information obtained by a local fetal, infant, and child mortality review team are not subject to disclosure under the public records law. Material and information obtained by a local fetal, infant, and child mortality review team are not subject to subpoena.

History: En. Sec. 4, Ch. 519, L. 1997; amd. Sec. 3, Ch. 413, L. 2003.

50-19-405. Unauthorized disclosure -- civil penalty. A person aggrieved by the use of information obtained pursuant to 50-19-402(2) for a purpose not authorized by 50-19-402(3) or by a disclosure of that information in violation of 50-19-402(2) may bring a civil action in the district court of the county of the person's residence for damages, costs, and fees as provided in 50-16-553(6) through (8) or 50-16-817.

History: En. Sec. 5, Ch. 519, L. 1997; amd. Sec. 12, Ch. 396, L. 2003; amd. Sec. 4, Ch. 413, L. 2003.

50-19-406. Unauthorized disclosure -- misdemeanor. A person who knowingly uses information obtained pursuant to 50-19-402(2) for a purpose not authorized by 50-19-402(3) or who discloses that information in violation of 50-19-402(2) is guilty of a misdemeanor and upon conviction is punishable as provided in 46-18-212.

History: En. Sec. 6, Ch. 519, L. 1997; amd. Sec. 13, Ch. 396, L. 2003; amd. Sec. 5, Ch. 413, L. 2003.



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